STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155464		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/12/2011	
	PROVIDER OR SUPPLIER LLE NURSING AND	REHABILITATION CENTER	STREET 7	ADDRESS, CITY, STATE, ZIP CODE DRTH US HIGHWAY 41 /ILLE, IN47872	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for Complaint IN000 Federal/State def allegations are ci F279, & F514. Survey dates: Ma Facility number: Provider number AIM number: 10 Survey team: Dia Census bed type: SNF/NF: 37 Total: 37 Census payor typ Medicare: 4 Medicaid: 18 Other: 15 Total: 37 Sample: 5 These deficiencie cited in accordance.	r the Investigation of 089659. 089659 - Substantiated. iciencies related to the ted at F157, F250, F272, ay 11 & 12, 2011 000492 : 155464 0291360 ane Dierks, RN	F0000	DEFICIENCY	
	~ auiity 10 110 11 01				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JC0C11

Facility ID:

000492

TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
ANDILAN	or correction	155464	A. BUILDING B. WING	00	05/12/2011
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET A	ADDRESS, CITY, STATE, ZIP CODE RTH US HIGHWAY 41 /ILLE, IN47872	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	NA CHIANTA N. L. C. CONTRACTOR	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0157	•	nediately inform the			
SS=D	resident; consult wand if known, notification representative or a when there is an a resident which respotential for requiring significant changemental, or psychosocial status conditions or clinical tertreatment significant changemental for requiring alter treatment significant changemental for conditions or clinical tertreatment significant in the psychosocial status conditions or clinical tertreatment significant readment for most or consideration of treatments for or discharfacility as specified. The facility must a resident and, if known there is a change in resident state law or regular paragraph (b)(1) or the facility must resident's legal registerit's legal registerity member.	with the resident's physician; by the resident's legal an interested family member accident involving the ults in injury and has the ing physician intervention; a in the resident's physical, social status (i.e., a alth, mental, or as in either life threatening all complications); a need to inficantly (i.e., a need to sting form of treatment due quences, or to commence a ment); or a decision to ge the resident from the drin §483.12(a). Iso promptly notify the bown, the resident's legal interested family member ange in room or roommate accified in §483.15(e)(2); or ant rights under Federal or ations as specified in of this section.			
	Based on intervie	ew and record review, the ensure the physician and	F0157	Preparation and/or execution this plan does not constitute admission or agreement by the state of the state o	*************************************

Facility ID:

li '		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155464	B. WIN	IG		05/12/2	011
NAME OF	PROVIDER OR SUPPLIEF	}	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
THE OI	I RO VIDER OR SOIT EIEI			768 NO	RTH US HIGHWAY 41		
ROCKVI	LLE NURSING AND	REHABILITATION CENTER		ROCKV	'ILLE, IN47872		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	X (EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	family were noti	fied of a significant			provider of the truth of the fa		
	change in psycho	osocial status for 1 of 3			alleged or conclusions set fo on the statement of deficience		
	residents review	ed for behaviors in a			This plan of correction is	JIES.	
	sample of 5 (Res	sident D).			prepared and/or executed so	olelv	
		,			because required. F 157 Not	-	
	Findings include	••			Changes (a) What corrective		
	1 manigs merade	·•			action(s) will be accomplishe		
	A Co.:114	1-4-1 F-1 2004			those residents found to hav	-	
	1	, dated February, 2004,			been affected by the practice		
		and Guidelines: Incident			and Family (for resident "D") notified of this resident havin		
	Reporting and Documentation," provided by the DON (Director of Nursing) on				displayed inappropriate sexu	-	
					behavior. Resident "D" care		
	5/11/11 at 3:45 p	o.m., included, but was			was revised to include	•	
	not limited to, th	e following:			interventions for inappropriat		
					sexual behavior. (b) How yo		
	"An event/inci	dent may be defined as:			will identify other residents		
		occurrence not consistent			having potential to be affect		
	1 ^	re of the resident. This			by the same practice and w corrective action will be tak		
		ay or may not cause			A facility audit was conducted	-	
	1	cidents may be related to			identify current Residents that		
	1	ff2. Notify the attending			experiencing inappropriate s		
					behaviors. No other Residen	ts	
	1 ^ *	ocument in the medical			were identified (c) What		
	record3. Notify	•			measures will be put into p or what systematic change		
	responsible party	у.''			you will make to ensure that		
					the practice does not recur		
	The clinical reco	ord review for Resident D			Licensed nursing staff was re		
	was reviewed on	1 5/11/11 at 4:00 p.m.			educated regarding MD/Fam		
					notification of displayed		
	Diagnoses for Re	esident D included, but			inappropriate sexual behavio		
	were not limited	to, Alzheimer's disease,			Facility staff were re-educat what actually is considered or		
	dementia with be	ehavior, psychosis,			represent displayed inapprop		
	delirium, anxiety	* *			sexual behavior, and the		
	1	teriosclerotic vascular			importance of notifying/repor	-	
	**	obstructive pulmonary			of displayed inappropriate se		
	1	hritis, malaise and			behavior activity so that this	can	
	Luisease, osteoart	mus, maiaise and					

000492

PRINTED:

FORM APPROVED

OMB NO. 0938-0391

06/06/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155464 05/12/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 768 NORTH US HIGHWAY 41 ROCKVILLE NURSING AND REHABILITATION CENTER ROCKVILLE, IN47872 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE fatigue, and difficulty walking. be addressed by medical personal. (d) How the corrective action(s) will be During an interview on 5/11/11 at 11:25 monitored to ensure the a.m., the DON indicated that incident practice will not recur, i.e., reports were not completed when CNA's what quality assurance program will be put into came to her with reports of Resident D's place: DNS /Designee will review inappropriate sexual behavior. She stated, 24 hour report to identify any "I told them to put it on the Behavior Log Resident with reported displayed - whether they did or not that's another inappropriate sexual behavior at story." the morning stand-up meeting. Any identified behaviors will result in review of Residents clinical During an interview on 5/11/11 at 4:05 record to assure documentation p.m., the DON indicated that no of MD/Family notification. Report investigation was done regarding the of the audits will be presented to the Risk Management meeting to incident when Resident D grabbed CNA# ensure compliance has been met 1 in a sexually inappropriate manner in and it is recommended that the shower room. oversight monitoring will be quarterly by the RDCO when system review is completed which During an interview on 5/11/11 at 4:24 includes review of behavior p.m., the DON indicated the incident of management and MD/Family Resident D grabbing CNA # 1, in a notification. Date of compliance: sexually inappropriate manner in the June 11, 2011 shower room, was a new behavior and it was not, to the best of her knowledge, documented in the chart or the Behavior Log. She also indicated the physician was not notified. She indicated Resident D's behavior had always been directed at staff, not residents, and this was the first time it had become physical. During an interview with the SSD (Social Services Director) on 5/12/11 at 10:05 a.m., she indicated CNA # 1 had reported

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		155464	A. BUILDING B. WING		05/12/2011
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	768 NO	DDRESS, CITY, STATE, ZIP CODE RTH US HIGHWAY 41 ILLE, IN47872	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	the vaginal area whim shower care, was the first time displayed physic inappropriate belindicated she rep the DON and the did not notify the				
F0250 SS=D	social services to a highest practicable psychosocial well-Based on intervie facility failed to adequately address the management behavior for 1 of	rovide medically-related attain or maintain the ephysical, mental, and being of each resident. ew and record review the ensure that social services assed and planned care for of sexually inappropriate are identification. The sexual services are identification of the sexual services are identification.	F0250	Preparation and/or execution this plan does not constitute admission or agreement by the provider of the truth of the falleged or conclusions set for on the statement of deficient This plan of correction is prepared and/or executed so because required. F-250	he cts rth cies.

STATE	MENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
	AN OF CORRECTION	IDENTIFICATION NUMBER:	(112) 1110 2111 22 0		COMPLETED	
ANDIL	ANOT CORRECTION	1	A. BUILDING	00		
		155464	B. WING		05/12/2011	
NAME	OF BROWNER OR GURBLUE	n.	STREET	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME	OF PROVIDER OR SUPPLIE	K	768 N	ORTH US HIGHWAY 41		
ROCK	(VILLE NURSING AN	D REHABILITATION CENTER	I	VILLE, IN47872		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON (X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO		ON
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	Findings includ	e:		Provision of Medically Re	elated	
				Social Service(a) What		
	The facility "Be	havior Log" book for the		corrective action(s) will be		
	1	· ·		accomplished for those re		
		ary through March 2011		found to have been affect	· I	
		n 5/11/11. There were no		the practice:Resident #D		
	behavioral entri	es listed for Resident D.		shown no further inappro		
				behaviors. The facility up		
	During an interv	view on 5/12/11 at 10:05		Resident D's care plan fo inappropriate behaviors.		
	-	Services Director (SSD)		Director of Social Service		
	· ·	` '		re-educated on the facility	I	
		aintained the Behavior		standards for timely and		
	1 -	ntries were to be		documentation and care	•	
	completed by al	l nursing staff, including		of those residents with		
	Certified Nursir	ng Aides (CNA). The SSD		inappropriate behaviors F	acility	
		d asked CNA # 1 to		nursing staff were reeduc		
		chavior Log book in regard		regarding documentation		
		_		behaviors timely per facil	·	
	1 ^	ncident in which Resident		standard(b) How you		
	D grabbed her is	nappropriately.		identify other residents	-	
				potential to be affected	- 1	
	The SSD indica	ted CNA # 1 did not		same practice and what	I	
	complete docum	nentation in the behavior		corrective action will be		
	1 *	ested. She explained CNA		Current residents were re	I	
	1 -	_		for any inappropriate beh		
	1	I to her that sometimes		displayed to ensure care and documentation are	pialis	
	Resident D wou	ld get "excited," meaning		completed.(c) What mea	ISIITAS	
	an erection wou	ld occur, during his		will be put into place or	I	
	showers or pers	onal care. CNA #1 also		systematic changes you		
	_	esident D had grabbed her		make to ensure that the		
		rivate) area, but it had		practice does not recur:	The	
	` *			Director of Social Service		
		ne he had displayed that		re-educated on the facility		
	behavior.			standards for timely and		
				documentation and care		
	The SSD indica	ted the behavioral incident		of those residents with		
	for Resident D	was discussed in the		inappropriate behaviors F	· I	
		ning meeting on 3/11/11.		nursing staff were reeduc		
		ecided Resident D's		regarding documentation	of	
			i			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	(X2) MULTIPLE CONSTRUCTION OU			(X3) DATE SURVEY COMPLETED	
AND TEAM	or conduction	155464		LDING		05/12/2	
		1.55.15.	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/12/2	
NAME OF	PROVIDER OR SUPPLIE	₹			RTH US HIGHWAY 41		
ROCKVI	LLE NURSING AND	REHABILITATION CENTER		1	ILLE, IN47872		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	FIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1 ^	d be obtained to change			behaviors timely per facility	_1	
	his shower times	s. The situation was			standard. Residents identifie with inappropriate behaviors		
	discussed and it	was agreed an evening			be reviewed at the Standard		
	shower provided	by a male CNA would			Care Meeting weekly by the		
	be advisable. Th	e SSD indicated she			Director of Social Service to		
	sometimes spoke	e to families about			ensure the resident's behavior		
		rs, but Resident D's			have been documented time	ly	
		tified about his reported			and a care plan in place for addressing those behaviors.	The	
	behaviors.				Facility Management Team v		
	0 3114 / 1015.				review any resident grievano		
	The SSD indicat	ed she was part of the			concerns, events and any ot		
		linary team) and is a			issues during the Monday th		
	· · ·	• /			Friday stand up meeting in o to investigate, resolve, and	raer	
		e care planning process			follow-up with any resident,		
		residing at the facility.			family, or staff concerns in a		
		re plan located related to			timely manner. (d) How the		
		ually inappropriate			corrective action(s) will be		
		ndicated the MDS			monitored to ensure the		
	1	nimum data set of			practice will not recur, i.e.,		
	assessments for	guiding a resident's care)			what quality assurance program will be put into pla		
	was the person r	esponsible for care plan			The Director of Social Service		
	updates. The MI	OS coordinator was not			designee will randomly revie		
	available for inte	erview. The SSD			residents medical records we		
	indicated the gra	bbing incident of			x 4 weeks, then monthly for 2		
	Resident D would	ld be considered abusive			additional months to determi	ne if	
	behavior as she	stated, "Yes I would, if it			any resident behaviors are documented and care planne	-d	
	had happened to				timely.The Facility Risk Mana		
					will report results at the next		
	This federal tag	is related to Complaint			QA/Risk Management meeti	ng	
	IN00089659.				and monthly thereafter until		
	1100007037.				substantial compliance has tachieved and then quarterly	peen	
	2 1 24(2)				monitoring to maintain		
	3.1-34(a)				compliance (e) Date of		
					compliance:		
					6/11/11		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DUILI DING	00	COMPLETED
		155464	A. BUILDING B. WING		05/12/2011
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER		l	ORTH US HIGHWAY 41	
ROCKVII	LE NURSING AND	REHABILITATION CENTER	l l	VILLE, IN47872	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0272 SS=D	The facility must operiodically a comstandardized represent resident's fur. A facility must make assessment of a re. RAI specified by the must include at least Identification and of Customary routine Cognitive patterns Communication; Vision; Mood and behavior Psychosocial well-Physical functioning Continence; Disease diagnosis Dental and nutrition Skin conditions; Activity pursuit; Medications; Special treatments Discharge potentian Documentation of regarding the additional performed through protocols; and Documentation of Based on observative record review, the complete assessing accurately recognise and performed through protocols; and pocumentation of Based on observative record review, the complete assessing accurately recognised the record recognised the performed through protocols; and pocumentation of Based on observative record review, the complete assessing accurately recognised.	onduct initially and prehensive, accurate, oducible assessment of nctional capacity. The accomprehensive esident's needs, using the ne State. The assessment ast the following: demographic information; especially and structural problems; and health conditions; and status; The and health conditions; and status; The and procedures; ali, summary information tional assessment in the resident assessment. The accomprehensive esident's needs, using the needs, using the needs and problems; and health conditions; and status; The accomprehensive esident's needs, using the needs assessment in the resident assessment. The accomprehensive esident's needs, using the needs assessment in the resident assessment. The accomprehensive esident's needs, using the needs assessment in the resident assessment. The accomprehensive esident's needs, using the needs assessment in the resident assessment. The accomprehensive esident's needs, using the needs assessment in the resident assessment.	F0272	Preparation and/or execution this plan do not constitute admission or agreement by the provider of the truth of the facility alleged or conclusions set for on the statement of deficiency. This plan of correction is	the octs
		3 residents reviewed for ample of 5 (Resident D).		prepared and/or executed so because it is required.	olely

PRINTED:

06/06/2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155464 05/12/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 768 NORTH US HIGHWAY 41 ROCKVILLE NURSING AND REHABILITATION CENTER ROCKVILLE, IN47872 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Findings include: F-272 Review of a facility policy, dated 2005 **Comprehensiv** and revised April 2007, titled "Problematic Behavior Management e Assessment Clinical Protocol," provided by the (A) What corrective action will be Director of Nursing (DON) on 5/11/11 at accomplished for those residents 3:45 p.m., included, but was not limited found to have been affected by this practice: Resident D was to, the following: assessed for Behavioral concerns and the Behavior Log was "...Nursing staff will document the nature, updated. (B)How will you identify duration, and associated features of any other residents having the changes over time in behavior, cognition, potential to be affected by the same practice, and what or mood...In addition, the nurse shall corrective action will be taken: A assess and document/report the comprehensive audit was following:..d. Whether resident is a conducted of active residents with Behavioral issues to ensure danger to themselves or others....e. Onset, behaviors were appropriately duration, severity of current symptoms...o. documented on the Behavior log. Full description of behavior compared to (C)What measures will be put usual behavior...If the resident is being into place or what systemic treated for problematic behavior or mood, changes you will make to ensure that the practice does the staff and physician will seek and not recur: Staff to be educated document objective reassessments of regarding Problematic Behavior positive or negative changes in the Management and related policy individual's behavior, mood, and and procedures by DNS or function...." designee (D)How will the corrective action(s) be monitored to ensure the practice will not A facility policy, dated February 2004, recur, what quality measures will titled "Standards & Guidelines: Incident

following:

Reporting and Documentation," provided

by the DON on 5/11/11 at 3:45 p.m.,

included, but was not limited to, the

be put into place: The DNS and/or designee will randomly audit at

least 5 residents medical records

weekly for 4 weeks and monthly

for 2 months to ensure residents

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIT	LDING	00	COMPL	ETED
		155464	A. BUI B. WIN	LDING		05/12/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹		1	RTH US HIGHWAY 41		
BOCK/I	LLE NUIDOING AND	DEHABILITATION CENTED		1	ILLE, IN47872		
KOCKVI	ROCKVILLE NURSING AND REHABILITATION CENTER			ROCKV	ILLE, IN47072		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN ((X5)
PREFIX	· ·	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					behavioral issues are		
	"The licensed	nurse will conduct a full			documented on the Behavio	•	
	physical and/or r	mental assessment on any			and present in the residents		
		to any incident. The nurse			medical record. Findings of t audits will be reported at the		
		the medical record their			facility's monthly Risk		
		ng any comments made by			Management/QA Committee	:	
		ig any comments made by			meeting to determine that		
	the resident"				compliance has been achiev	ed	
					and quarterly monitoring is		
	The clinical record review for Resident D was reviewed on 5/11/11 at 4:00 p.m. The record noted diagnoses for Resident D included, but were not limited to:				recommended. (E) Date of		
					compliance: 6-11-11		
	· ·	ase, dementia with					
		osis, delirium, anxiety,					
	and alcohol abus						
	and alcohol abus	sc.					
	TEL 6 11: UD 1						
	1	navior Log" book for the					
		ry through March 2011					
	was reviewed on	5/11/11. The log					
	indicated no beh	avioral entries were listed					
	for Resident D.	During an interview on					
		a.m., the Social Services					
		ndicated the Behavior					
	` ′	aintained by her, but					
	1 -	e completed by all					
		-					
	I -	eluding Certified Nursing					
	Aides (CNA).						
	_	avior/Intervention Log",					
	located in the Mo	edical Administration					
	Record, was reviewed on 5/12/11 for the						
	· ·	n through May. The					
		no entries for any					
		ors for March April or					

000492

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155464	A. BUII	LDING	NSTRUCTION 00	(X3) DATE S COMPL 05/12/2	ETED
		100 10 1	B. WIN		DDDEGG CITY GTATE ZID CODE	00/12/2	011
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE RTH US HIGHWAY 41		
ROCKVI		REHABILITATION CENTER		1	/ILLE, IN47872		
(X4) ID		STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	the current date of May 12, 2011.			TAG	DEFICIENCY)		DATE
	the current date (or May 12, 2011.					
	During observati	ion on 5/12/11 at 6:05					
	1	was in his room sitting					
	1 *	while chewing tobacco.					
		icated that he was					
		e amount of showers and					
	care provided by						
	care provided by						
	During an interview with the DON on						
	5/11/11 at 11:25 a.m., she indicated						
	Resident D had verbalized sexually						
	inappropriate comments to some CNA's,						
	"It was usually n	new CNA's. He would like					
	to test their bour	idaries and see what he					
		h." The DON indicated					
	when CNA's can	ne to her with information					
	about those type	of behaviors, no incident					
	1	npleted. She stated, "I told					
	them to put it on	the Behavior Log -					
	whether they did	or not, that's another					
	1	I indicated there had been					
	1 -	of physical, sexually					
	inappropriate be	havior with CNA # 1. At					
	4:54 p.m. the sar	ne day, the DON					
	indicated the gra	bbing of CNA # 1 in the					
	shower was new	behavior for Resident D.					
	She said the resi	dent's behaviors were					
	always directed	at staff, not residents, and					
	the reported grab	obing incident of CNA #1					
	was the first time	e he had been physical.					
	During an interv	iew with CNA # 1 on					
	5/11/11 at 12:35	p.m., she indicated					

000492

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155464	(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMP 05/12/2	LETED
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	D. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE RTH US HIGHWAY 41 ILLE, IN47872		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROIDEFICIENCY)	BE	(X5) COMPLETION DATE
	she was giving he grabbed my crotorindicated this occherself and getting. She stated that at be an accident, be to her, "Haven't yfeel before?" She that he understood stated, "My first and - but I know then indicated Ref. "Well a hot thing happy a guy like. She stated she has reported the incident of the going to do it indicated she was ent out for psychological properties. An interview with 1:25 p.m., indicated werbally-sexually shower care, but and she reported.	inappropriately while im a shower. "He ch in the shower." She curred while she was by ag the resident dressed. If first she thought it might tut then the resident said you ever had a guy cop a chindicated she knew then ad what he had done. She instinct was to haul off the we can't do that." She esident D said to her, like you should be me can get a b" If we decused herself and dent to the DON. CNA # wanted Resident D to be the hiatric treatment or to file tim. She stated, "My check done it to me, who is to next?" CNA # 1 is told by administration the tille charges against him in a nursing home. The CNA # 3 on 5/11/11 at the december of the hiatric to the laddent D had been to inappropriate during it only happened once the behavior to the also had documented in grant of the said of the laddent of th					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155464	B. WIN			05/12/2	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	ę.		768 NO	RTH US HIGHWAY 41		
		REHABILITATION CENTER			/ILLE, IN47872		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)	-	TAG	BLI ICILIACI)		DATE
		ew with CNA # 1, on					
	1	p.m., indicated she may					
		the incident in the					
	1	it confirmed the incident					
	1	ch of 2011, at which time					
	it had been repor	rted it to the DON.					
	During an interv	iew with Licensed					
	"	(LPN) # 9 on 5/12/11 at					
	12:35 p.m., she indicated she first started						
	at the facility in 12/2010. She indicated						
	while she was new, Resident D made						
	verbalizations of sexual content in						
		genitalia. She had been					
	1	s medication at that time					
	~	the incident to the DON.					
	and she reported	the medent to the BOIV.					
	During an interv	iew on 5/12/11 at 2:15					
	p.m., CNA # 10	indicated he had provided					
	shower care to R	Resident D for the past					
	couple of month	s. The CNA said he only					
	works 3 to 4 day	s a week, but there were					
	other female stat	ff who provided showers					
		the evenings that he did					
		# 10 indicated during					
		ower care, the resident had					
	made reference t	•					
	1	havior with the female					
	1	"just got a little touch					
	and that's it."						
	and that bit.						
	The Administrat	or, during an interview on					
		p.m., confirmed the lack					
		ecurrences documented in					

		3) DATE SURVEY COMPLETED			
THEFTERN	or condection	155464	A. BUILDING B. WING	00	05/12/2011
NAME OF D	DOMED OF GLIDDLIED			DDRESS, CITY, STATE, ZIP CODE	
	ROVIDER OR SUPPLIER		I	RTH US HIGHWAY 41	
		REHABILITATION CENTER		'ILLE, IN47872	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE
	the Behavior Log	g book. She indicated			
	documentation of	f observed behavioral			
		be one of the first things			
	to happen with th	nose observations.			
	This federal tag i	s related to Complaint			
	IN00089659.	s related to Complaint			
	3.1-31(a)				
	3.1-31(c)(7)				
F0279	A facility must use	the results of the			
SS=D	assessment to dev	velop, review and revise the			
	resident's compreh	nensive plan of care.			
	The facility must d	evelop a comprehensive			
		resident that includes			
	_	tives and timetables to meet al, nursing, and mental and			
	psychosocial need	ls that are identified in the			
	comprehensive as	sessment.			
	-	st describe the services that			
		to attain or maintain the practicable physical,			
		osocial well-being as			
		83.25; and any services that			
		e required under §483.25 ed due to the resident's			
	exercise of rights u	under §483.10, including the			
	_	tment under §483.10(b)(4).	F0279	Preparation and/or execution	n of 06/11/2011
		ensure a care plan was	102/9	this plan do not constitute	**, **, ***
	_	ntions provided, and		admission or agreement by t provider of the truth of the fa	I
		ored for a resident who		alleged or conclusions set fo	
	1 2 11	opriate sexual behavior		on the statement of deficience	.
	for 1 of 3 resider			This plan of correction is prepared and/or executed so	blely
	behaviors, in a sa	ample of 5 (Resident D).		property and an area of oxidated oc	- /

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDI		00	COMPLETED	
		155464	A. BUI B. WIN			05/12/2	011
		<u> </u>	D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				1	ORTH US HIGHWAY 41		
ROCKVILLE NURSING AND REHABILITATION CENTER					/ILLE, IN47872		
ROCKVILLE NORSING AND REHABILITATION CENTER					, IN47072		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	1	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG			DATE
					because it is required. F279		
	Findings include	2:			Comprehensive Care Plans A. What corrective action will be		
					accomplished for those resi		
	The clinical reco	ord review for Resident D			found to have been affected		
	was reviewed or	n 5/11/11 at 4:00 p.m.			this practice: A care plan for		
		eated the following			Resident D addressing behavioral issues was immediately developed and implemented.B.		
	1	esident D included, but					
	1 -						
		to: Alzheimer's disease,			How will you identify other	-14-	
	dementia with behavior, psychosis, delirium, anxiety, alcohol abuse"				residents having the potenti be affected by the same pra		
					and what corrective action v		
					taken: A comprehensive au		
	During an interviewn with CNA # 1 on 5/11/11 at 12:35 p.m., she indicated Resident D acted inappropriately while she was giving him a shower. "He grabbed my crotch in the shower." She				all active residents' medical		
					record was conducted to ide	entify	
					those residents with Behavi		
					issues and ensure they wer		
					appropriately care planned.		
	1 "	r occurred while she was			What measures will be put	into	
					place or what systemic changes you will make to		
	1 '	etting the resident dressed.			ensure that the practice do	000	
	At first she thought it might be an				not recur: An in-service wa		
	accident, but then the resident said to her,				conducted for the interdiscip	-	
"Haven't you ev		er had a guy cop a feel			team using Chapter 4 of the		
	before?" She inc	licated she knew then that			manual as it pertains to		
	he understood w	that he had done. She			development of a plan of ca		
	stated, "My first	instinct was to haul off			review procedures for devel		
	1 ' -	we can't do that." She			a comprehensive care plan,		
	indicated Resident D said to her, "Well a hot thing like you should be happy a guy like me can get a b" She stated she excused herself and reported the incident to the DON. CNA # 1 indicated she				including resident specific, individualized interventions	and	
					possible side effects of	ana	
					medications. D. How will the	ne	
					corrective action(s) be moni		
					to ensure the practice will no		
					recur, what quality measure		
	wanted Resident	D to be sent out for			be put into place: The Direc		
	psychiatric treat	ment or to file charges			Nursing or Designee will mo corrective actions to ensure		
	against him. She stated, "My thoughts are, if he's done it to me, who is he going to do				effectiveness of these action		
					including: · Randomly audit		

		(1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NUMBER: 155464	A. BUI	LDING	00	05/12/2		
155404			B. WIN			05/12/20	011	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE			
ROCKVILLE NURSING AND REHABILITATION CENTER				1	PRTH US HIGHWAY 41 /ILLE, IN47872			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	, - 	(X5)		
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	DATE	
	it to next?" CNA # 1 indicated she was				least 5 resident's comprehensi			
	told by administr	ration that she could not			care plans weekly for 4 week			
	file charges agair	nst him because he was in		and then monthly for 2 months ensure the care plan accurate				
	a nursing home.			reflects Behavioral issues.		, Siy		
				Findings monthly	Findings will be reported at t			
	Additional staff i	nterviews were			monthly QA/Risk Manageme	ent		
	conducted related	d to Resident D's			meeting until substantial compliance is achieved and			
	inappropriate bel	navior. They are as			quarterly monitoring is			
	follows:				recommended. Date of			
					Compliance: 6-11-11			
	CNA#3 was interviewed on 5/11/11 at 1:25 p.m. She indicated Resident D had been verbally sexually inappropriate during shower care, but it only happened once. She reported the incident to the charge nurse and documented the behavior in the Behavior Log book.							
	Licensed Practical Nurse (LPN) # 9 was							
	interviewed on 5	/12/11 at 12:35 p.m. She						
	indicated she had	I started at the facility						
	12/2010. She inc	dicated Resident D had						
	been sexually ina	appropriate to her when						
	he made commer	nts in reference to her						
	genitalia. She ind	licated the incident						
	happened during medication							
		nd she reported the						
	incident to the DON. A quarterly Minimum Data Set (MDS-an assessment tool that is used to guide a resident's care), dated 3/9/11, indicated Resident D required extensive assistance of one person for bathing and the only							

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LDING	00	COMPLETED	
155464		155464	B. WIN			05/12/2011	
					ADDRESS, CITY, STATE, ZIP CODE	<u>!</u>	
NAME OF PROVIDER OR SUPPLIER					RTH US HIGHWAY 41		
ROCKVILLE NURSING AND REHABILITATION CENTER				ROCKV	/ILLE, IN47872		
(X4) ID		STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECT			
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)	-	TAG			DATE
	behavior indicate	ed was rejection of care.					
		alth care plan, with an					
	original date of 9	9/17/10 and a goal date of					
	6/14/11, included	d "resists care" as a					
	behavior probler	n, but did not include					
	"sexually inappr	opriate" as a behavior					
	problem.						
	During an interv	riew with the DON on					
	5/11/11 at 4:05 p.m., she indicated the only intervention put in place to address the sexually inappropriate behavior of Resident D was the rearrangement of the shower schedule, so that showers would be given by the male CNA. During an interview with the						
	Administrator or	n 5/11/11 at 4:24 p.m., she					
	indicated the sexually inappropriate incident that had occurred in the shower room with Resident D on 3/10/11 was						
	discussed at the	morning meeting on					
	3/11/11. She indicated the Social Services Director had spoken to Resident D about the incident. She indicated interventions from the morning meeting were not						
	documented, but it was decided Resident						
	D would not receive shower care from						
	female staff, unless the female staff agreed and there had been no occurrences						
	1 -						
	of sexually inappropriate behavior by						
		the female staff. She					
	indicated there should have been a care						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION 00			(X3) DATE SURVEY COMPLETED		
155464			A. BUILD! B. WING	ING		05/12/20		
NAME OF PROVIDER OR SUPPLIER ROCKVILLE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 768 NORTH US HIGHWAY 41 ROCKVILLE, IN47872					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL PEGLIL ATORY OR LSC IDENTIFYING INFORMATION)		PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0514 SS=D	plan in place for Resident D's sexually inappropriate behavior. No behavioral care plan for sexually inappropriate behavior with interventions of care, was located or provided by the facility. This federal tag is related to Complaint IN00089659. 3.1-35(a) The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care			TAG			DATE	
	and services proving preadmission screed State; and progress Based on intervier facility failed to endocumentation of behavior by a restricted for the services of the service	ded; the results of any ening conducted by the is notes. ew and record review, the ensure complete if sexually inappropriate ident was located in the r 1 of 3 residents avioral documentation, in esident D).	F051	14	Preparation and/or execution this plan does not constitute admission or agreement by the provider of the truth of the fact alleged or conclusions set for on the statement of deficience. This plan of correction is prepared and/or executed so because required. F 514 Clin Records (a) What corrective action(s) will be accomplished those residents found to have been affected by the practice.	ne cts rth ies. lely ical d for	06/11/2011	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155464 05/12/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 768 NORTH US HIGHWAY 41 ROCKVILLE NURSING AND REHABILITATION CENTER ROCKVILLE, IN47872 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE During an interview with the SSD (Social SSD was re educated per teachable moment for standard Services Director) on 5/12/11 at 10:05 and guideline for documentation a.m., the SSD said she had been told by of behaviors. Resident D clinical staff that Resident D had a history of record has been updated with documentation to reflect the inappropriate sexual comments toward the inappropriate sexual behavior, CNA's, mainly in the shower room or including MD/Family notification. . during personal care. She indicated CNA (b) How you will identify other # 1 had reported to her a behavioral residents having potential to incident involving Resident D, that be affected by the same practice and what corrective occurred on 3/10/11. The SSD had action will be taken: . An audit recorded the incident in her personal was conducted of residents with notebook, but not the clinical record. She inappropriate sexual behaviors retrieved her personal notebook, which with no other residents identified. contained, but was not limited to, the (c) What measures will be put into place or what systematic following documentation: changes you will make to ensure that the practice does "...3/11/11 8 a.m. Writer notified by CNA not recur: Staff will be of inappropriate touching during shower re-educated on standards and by res(resident). CNA very guidelines for documentation and behavior management of uncomfortable. Writer requested CNA inappropriate sexual behavior, document in behavior book....Writer and professional standards of approached res while he was sitting in practices for maintaining clinical chair in his room. Writer asked res, 'Do record documentation. (d) How the corrective action(s) will be you remember taking a shower yesterday?' monitored to ensure the Res said 'Yes.' Writer asked, 'Did you practice will not recur, i.e., touch CNA (name) inappropriately?' Res what quality assurance stated, 'Yes. Why shouldn't I?' 'I believe program will be put into place: that a man can touch a woman whenever DNS/Designee will review the 24 report during stand up meetings he wants.' Writer explained that we can't to identify any resident touch others there and he got agitated with experiencing unusual or sexual me and said, 'I'm a man I can do whatever behavior for the next four weeks I damn want.' Writer explained again why then twice a month X 2 months. Any issues identified will result in touching was inappropriate and res started review of the Residents clinical shaking his fist and yelling, 'Get the hell

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00		00	COMPLETED				
155464			B. WIN			05/12/20	711		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE					
DOOM /// LE NILIDONIO AND DELIADII ITATION CENTED				768 NORTH US HIGHWAY 41					
ROCKVILLE NURSING AND REHABILITATION CENTER			ROCKVILLE, IN47872						
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)		
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE		
IAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		+	IAG	record for appropriate				
	outta here.' Writer asked if res would like				documentation including				
	to switch his shower day to the evening with a male CNA and he said, 'I don't care				MD/Family notification. The				
		*			above audits will be reviewed				
	just get the hell outta my room.' Writer left and reported to DON (Director of				the next Risk Management/C committee meeting to detern				
	•	*			if compliance has been met				
	Nursing) and charge nurse explaining situation, change of shower time/day. Staff agreed that our male CNA (name) would shower res. from now on."				recommended that monitoring	ng will			
					be quarterly by the RDCO w	nen			
					she completes her system reviews which includes beha	avior			
	would snower re	. from now on."			monitoring and documentation				
	The clinical record review for Resident D was reviewed on 5/11/11 at 4:00 p.m. The record noted diagnoses for Resident D included, but were not limited to: Alzheimer's disease, dementia with behavior, psychosis, delirium, anxiety,				(e) Date of compliance: 6/1				
	and alcohol abuse."								
	There was no complete documentation								
		T (Interdisciplinary							
	Team) notes, or clinical record for								
	-	rovided by the facility,							
		the resident's sexually							
	inappropriate bel	navior.							
	This Federal tag is related to Complaint IN00089659. 3.1-50(a)(1)								